DELAWARE HEALTH AND SOCIAL SERVICES
Division of Substance Abuse and Mental Health/ Division of Public Health

Mental Health Association in Delaware

DELAWARE SUICIDE
PREVENTION COALITION

"Give light and people will find the way."

–Ella Jo Baker

Prepared by
Delaware Suicide Prevention Coalition
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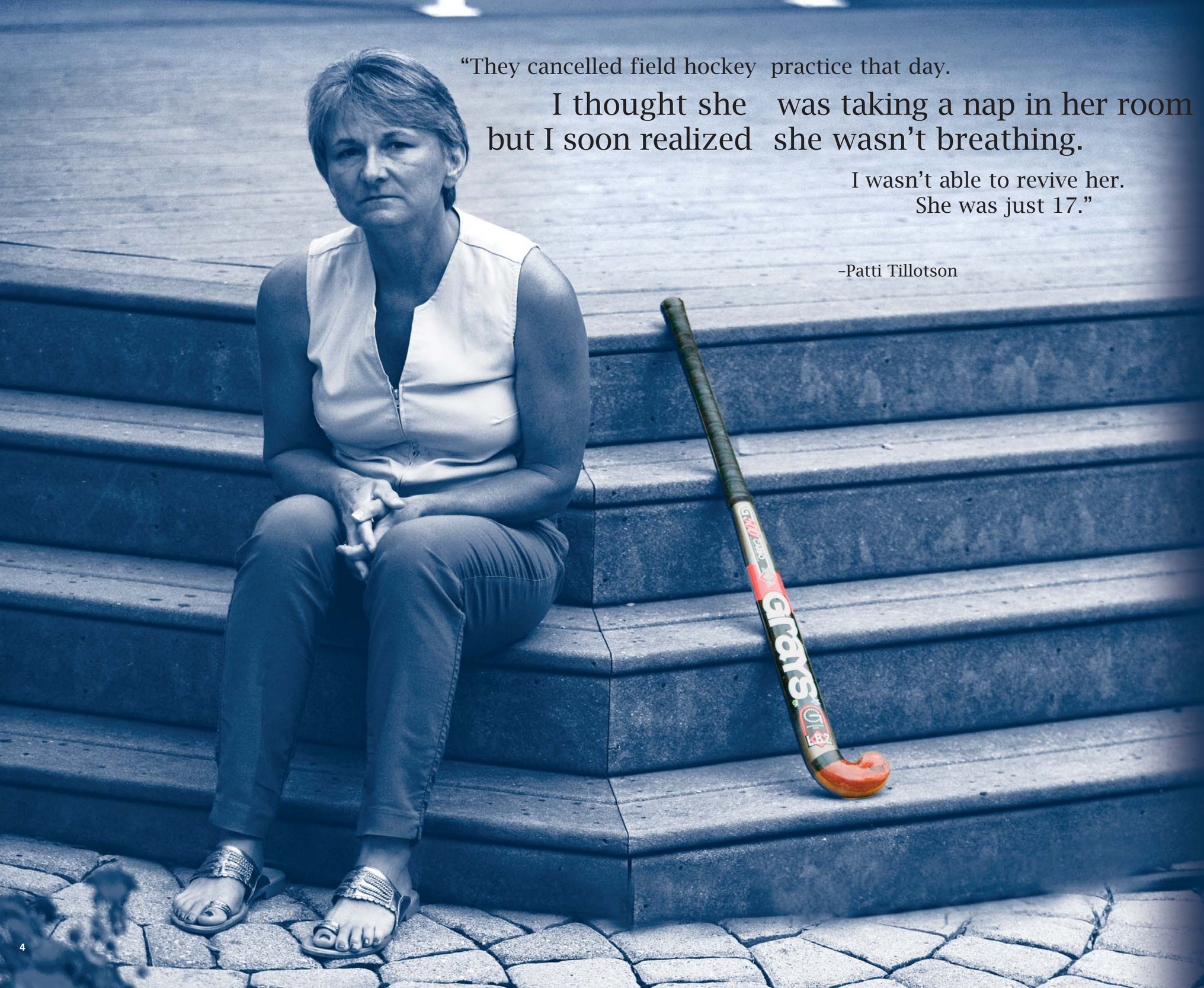


On the honor roll, captain of the field hockey team, blonde and beautiful, Stephanie was the classic popular high school student. But she was diagnosed with depression in 2005. Her life got more complicated when she experienced a date rape a few months after that. Less than a year later, she took her life.

Every life holds value beyond compare, but, on average in the State of Delaware, we lose one precious life to suicide every four days—90 lives annually. Suicide is a major public health issue for Delaware, resulting in more than 2.5 times as many deaths each year as homicide. For those aged 15–24, suicide was the third-leading cause of death between 2001 and 2005.

The number of completed suicides reflects only a small portion of the impact of suicidal behavior. Every year there is an average of 478[1] hospitalizations statewide due to suicide attempts. However, in 2005, there were 568 hospitalizations due to suicide attempts. In a typical Delaware high school classroom of 30 students, approximately four students will seriously consider suicide and at least one will attempt suicide. These statistics have remained relatively stable from 2001 to 2005.

[1]Delaware Hospital Discharge Data. This data is occurrence data and captures everyone who is admitted to Delaware acute care hospitals for suicide attempts for both residents and non-residents.

Worldwide, more people die by suicide than from all homicides and wars combined. We cannot be complacent.

There's an urgent need for coordinated and intensified global action to address this preventable tragedy.[2] The World Health Organization estimates that one million fatalities occur each year due to suicide. In the United States, according to the American Foundation for Suicide Prevention (AFSP), someone dies by suicide every 16 minutes. The nature of suicide in Delaware is no exception. It is the tenth-leading cause of death among residents[3] and the third-leading cause of death for those aged 15–24.

To address suicide as a critical public health problem, the Delaware Secretary of Health and Human Services initiated the Delaware Suicide Prevention Coalition to decrease the rate and number of suicides across the state. The Coalition includes founding members from public and private organizations and government agencies. The Suicide Prevention Coalition, headed by the Department of Health and Social Services, Division of Substance Abuse and Mental Health (DSAMH), and the Mental Health Association in Delaware (MHA), began efforts in 2004. These two agencies enlisted multiple state, private and nonprofit organizations to participate in the effort. Currently, a statewide Suicide Prevention Steering Committee leads efforts of the Coalition to ensure a coordinated strategy of prevention and to aid communications among members and across agencies.

Thus far, the Suicide Prevention Coalition has worked vigorously to raise awareness about suicide in the state. As a whole the Coalition believes that educating the community will alleviate multiple misconceptions about mental illness and suicide/suicide prevention. The Coalition developed a statewide suicide prevention plan that creates a seamless pathway for interventions and preventative measures across the entire life span of all Delaware residents. This comprehensive Suicide Prevention Plan is modeled after known best practices and the established goals of the National Suicide Prevention Plan.

[2]World Health Organization, Website, June 21, 2007, http://www.who.int/mediacentre/news/releases/2004/pr61/en/.
[3]Delaware Vital Statistics Summary Report, 2005.

Strides made to date include:

- Establishment of the Suicide Prevention Coalition consisting of multiple states, private organizations and nonprofit agencies;
- Successful completion by coalition members of a two-day Core Competencies Training Program presented by the National Suicide Prevention Resource Center (NSPRC) in preparation for developing a comprehensive suicide prevention plan for Delaware;
- Collation of a comprehensive set of statistics and demographics for suicide in the State of Delaware to characterize the nature of suicide in the state;
- Placement of the National Suicide Prevention Lifeline Number (1-800-273-TALK) on the Delaware River and Bay Authority's digital billboard on the Delaware Memorial Bridge;
- Hosting of the first two annual Suicide Prevention Conferences in the State of Delaware with over 400 participants each[4];
- Identification and coordination of existing crisis services across the state; and
- Raising of more than $7,500 in private funding through Steps for Steph[5].

[4]President Bush recognized Delaware's 2nd annual conference for its contribution to suicide prevention and awareness, April 2007.
[5]For more information on Steps for Steph: www.stepsforsteph.com/.

Delaware's Goals for Suicide Prevention are threefold:

- To prevent suicidal behaviors by enhancing resiliency, increasing awareness and promoting the education of Delaware residents about suicide risk and its protective factors.
- To improve support of individuals, families and communities affected by suicide or suicidal behaviors.
- To improve accessibility, availability and continuity of suicide prevention care.

Suicide is a preventable public health problem. Mental health is manageable.

These two essential tenets offer hope that the efforts to mitigate suicide in Delaware can be successful. And each person reading this document needs to spread the word. Every one of us must hold a sense of urgency in our hearts that we can save lives. Devastation left in the wake of suicide cannot be brushed aside nor described simply by numbers. The grief caused by suicide is heartfelt. It is about the loss of precious human life. We all have a responsibility to do what is necessary to prevent the needless loss of valuable human life. These individuals are real. They are our fathers, mothers, sisters, brothers, children, spouses and friends. They have real names, real faces. The loss is overwhelming and the grief, guilt and pain are agonizingly real for those left behind. The time has come to make prevention a priority. The time has come to make a difference.

Conceptual Framework

The Coalition supports the Strategic Prevention Framework developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) as their overall prevention framework. The framework enables the Coalition to build an infrastructure necessary for the integration of culturally competent guidelines and for the effective and sustainable prevention of suicide. The five steps of SAMHSA's Strategic Prevention Framework used to create the suicide prevention plan are:

1. **Profile Delaware's population's needs, resources and readiness** to address needs and gaps in the suicide prevention and treatment of youth;
2. **Mobilize and build the capacity of public and private community agencies** to address the needs of individuals who are at risk for suicidal behaviors;
3. **Develop a comprehensive strategic plan** that includes the evaluation of the effectiveness, efficiency and fidelity of programs, policies and practices selected to target populations across the life span;
4. **Implement evidence-based suicide prevention programs, policies and practices;** and
5. **Monitor, evaluate, and improve or replace programs, policies and practices** that fail to achieve the performance outcomes.

The task of the Suicide Prevention Coalition is not a simple one. Its ultimate mission is to raise awareness that suicide is a preventable public health problem and to enable the behavioral and social changes necessary to reduce suicidal ideation and attempts. The challenging nature of the mission contributes to the need for the Coalition to develop prevention approaches that are built on evidence-based methods and best practice strategies.

He was a remarkable artist, a devoted father and a department manager for a major airline. But at 26 years of age, Atif Hines put a gun to his head and killed himself. His brother Ishan has since learned the signs of depression—he has been diagnosed himself. Today he realizes his brother was suffering and never realized it.

"Atif had no idea he suffered from depression.

He had a great job and a daughter he adored.

But one day he bought a gun and killed himself."

–Ishan Hines

Prevention Strategies

Universal, selective and indicated strategies are used by the Coalition for suicide prevention. **Universal strategies** target and benefit everyone by addressing entire populations. They reduce suicide risk through the removal of barriers to care, the enhancement of knowledge of what to do and say to help suicidal individuals and an increase in access to programs that help and strengthen protective processes. They include public education campaigns, school-based "suicide awareness" programs, education programs for the media on reporting practices related to suicide, reducing access to firearms, and school-based crisis response plans and teams.

Selective strategies benefit specific high-risk groups or subsets of populations. The focus is on specific groups of individuals who have a greater probability of displaying suicidal symptoms. Prevention efforts include screening programs, gatekeeper training for frontline adult caregivers and "peer natural helpers." It may also include support and skill-building groups, as well as crisis and referral services.

Indicated strategies target and benefit identified high-risk individuals, especially those displaying early signs of suicide or a strong potential for suicide. Intervention programs may include skill-building training, support groups in high schools or colleges, parent support training programs, case management for youth and aging populations, and 2nd referral sources for crisis intervention and treatment.

Reducing Risk and Promoting Resiliency

The Coalition also integrated the philosophy of Hawkins and Catalano[6] during plan development. According to this philosophy, the first step in preventing suicide is to identify and understand the risk factors. Risk and protective factors are biological, genetic, psychological and cultural factors that significantly impact risk of suicide in individuals. Risk factors associated with suicide include serious mental illness, alcohol and drug abuse, childhood abuse, loss of a loved one, joblessness, loss of economic security, aging, and other cultural and societal influences. Protective factors are the positive conditions and personal and social resources that promote well-being and reduce the potential for suicide as well as other related high-risk behaviors. Suicide risks typically rise from interactions due to family, genetic and environmental factors. Protective factors also rise from these same interactions. Some protective factors include social support, close relationships and access to resources that reduce risk, as well as an individual's resiliency or coping skills.

[6]Hawkins and Catalano reviewed articles and documents during 30 years of research across a variety of disciplines. They identified 19 risk factors that are reliable predictors of adolescent delinquency, violence, substance abuse, teen pregnancy and school dropout. According to Hawkins and Catalano (1992), "Protective factors hold the key to understanding how to reduce those risks and how to encourage positive behavior and social development." For more information, refer to www.samhsa.gov.

Suicide is the 10th-leading cause of death among Delaware residents (2001–2005) and outnumbers deaths by homicide.

From 2001 to 2005, Delaware's suicide rate of 10.9 deaths per 100,000 residents was above the U.S. rate of 10.8 and also was higher than rates of its three surrounding states: New Jersey (6.49), Maryland (8.65) and Pennsylvania (10.7)[7]. Having a coordinated suicide prevention program in the state of Delaware clearly has potential to decrease the suicide rate and number of annual deaths due to suicide.

From 2001 to 2005 a total of 460 people died by suicide in Delaware, or approximately 92 every year. That means seven to eight Delawareans took their own lives each month on average, equivalent to one suicide death approximately every four days.

Table 1: Suicide Deaths and Rates by County in Delaware (2001–2005)

County	Suicide Rate	Homicide Rate
New Castle	11.2	5.3
Kent*	10.1	–
Sussex	10.4	3.6
Delaware	**10.9**	**4.5**

*Rates on 20 or fewer deaths may be unreliable.

(Source: Delaware Health Statistics Center, 2005 Annual Vital Statistics Report)

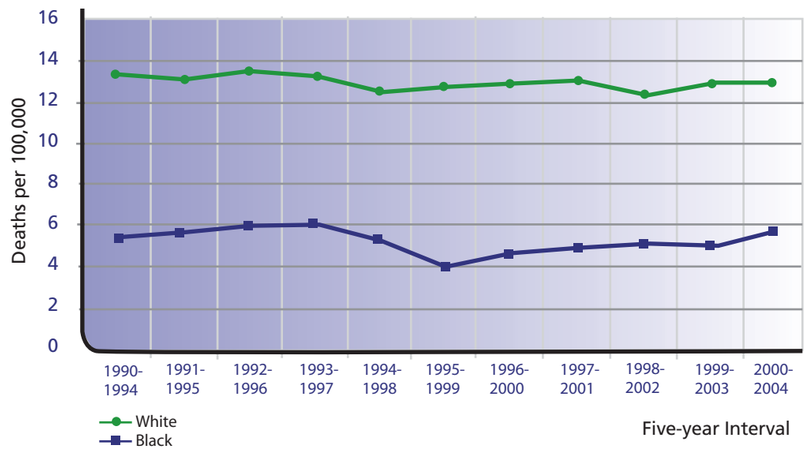
The number of lives lost to suicide was greatest in New Castle County where population is largest. The rate of suicide in Sussex County, the state's southernmost county, was also high based on the per capita population where access to mental health care is limited. Death by suicide was about 2.5 times greater than those by homicide in Delaware.

[7]Source: CDC, NCHS.

The rate of suicide mortality in the white population is more than double that of the black population.

Suicide mortality trends for both black and white populations in Delaware remained fairly constant over five-year intervals from 1990 to 2005, with the rate of suicide mortality in the white population being more than double that of the black population (see Figure 1). The consistency of suicide rates over the past decade potentially reflects the absence of a targeted approach to prevention. In Australia, where a nationwide initiative to prevent suicide deaths was implemented, the suicide rate dropped by an encouraging 29% from 2001 to 2005[8].

Figure 1: Five-year Age-adjusted Suicide Mortality Rates by Race, Delaware (1990–2005)



(Source: Delaware Vital Statistics Summary Report, 2005)

With the exception of Asian/Pacific Islanders, the number of suicide deaths and suicide rates are significantly higher in males than in females for all races. Of the 460 total suicide deaths in Delaware from 2001 to 2005, 363, or 79%, were male. Males are roughly four times more likely to die by suicide than females.

Table 2: Suicide Deaths by Gender, Delaware (2001–2005)

Gender	Total	Percent
Female	97	21
Male	363	79
Total	**460**	**100**

(Source: Delaware Health Statistics Center, 2005 Annual Vital Statistics Report)

[8]Medical Journal of Australia, 2006; 185(6):304.

The suicide rate is highest among those ages 80 and older.

From 2001 to 2005, a total of 460 people died by suicide in Delaware, or approximately 92 every year. That means seven to eight Delawareans took their own lives each month on average, equivalent to one suicide death approximately every four days.

In general, the suicide rate in Delaware increases with age up through age 49 then is highest among those ages 80 and older. The total number of lives lost for those 60 years of age and older is 76 or 16.5% of the total. If the trend in deaths by suicide in those age 60+ continues, Delaware can expect to see an increasing number of suicides over the next 10–20 years due to the aging population.

This statistical picture reflects only a partial view of the problem. The actual extent of suicide and suicidal behaviors is expectedly underreported. Forensic, social, cultural and religious factors influence whether or not a death is classified as suicide. Deaths caused by single-car auto accidents or deaths due to other unintentional injuries such as drug overdoses may also be suicide-related. Without a sustained, organized and intense commitment to prevent suicide, more lives will be lost needlessly. By identifying and targeting appropriate services for individuals at most risk of suicide, we can potentially reduce suicide and suicidal behaviors across the life span.

Table 3: Suicide Deaths by Age in Delaware (2001–2005)

Age	Suicide Deaths	Age	Suicide Deaths
10–14	4	50–54	59
15–19	26	55–59	40
20–24	30	60–64	15
25–29	35	65–69	12
30–34	42	70–74	17
35–39	48	75–79	11
40–44	62	80–84	11
45–49	71	85+	10
Total			**493***

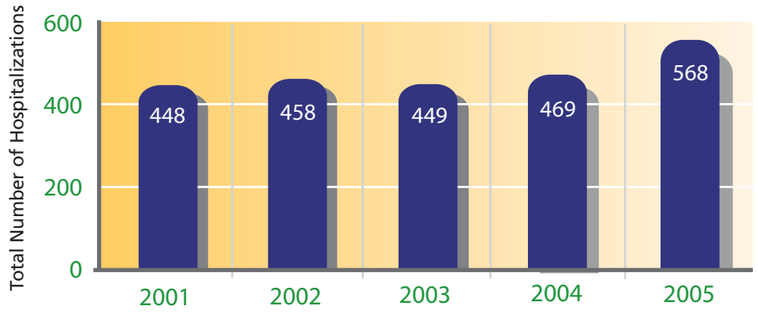
**Out-of-state residents account for 33 of these deaths.*
(Source: Delaware Health Statistics Center, 2005 Annual Vital Statistics Report)

Although suicide accounted for 1.2% of all deaths in Delaware (2001–2005), it comprised 11.4% (51) of all deaths of those aged 15–24 and was the third-leading cause of death in this age group (Mortality 2005, DE Vital Statistics Annual Report, Summer 2005).

On the average, suicide attempts accounted for at least one hospitalization daily.

In Delaware the number of hospitalizations due to suicide attempts fluctuated from 2001 to 2005, with a high/low of 568/448 hospitalizations, respectively. From 2001 to 2005, the numbers were more consistent, with an average of 478 hospitalizations. On the average, suicide attempts accounted for at least one hospitalization daily.

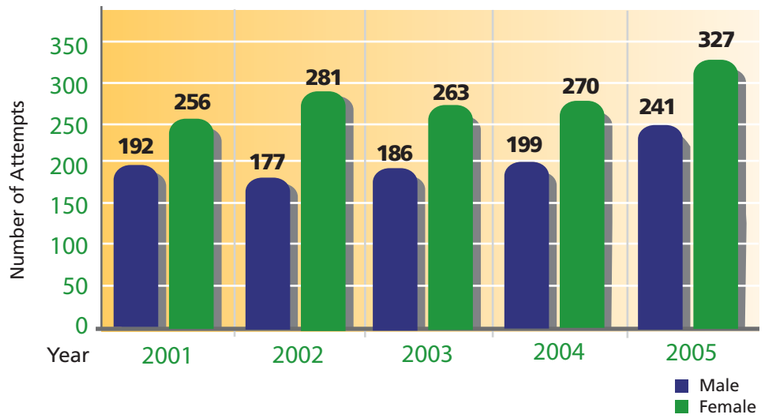
Figure 2: Hospitalizations for Suicide Attempts in Delaware (2001–2005)



(Source: Delaware Vital Statistics Summary Report, 2005)

Females were approximately 1.5 times more likely than males to attempt suicide in Delaware based on data from 2001 to 2005.

Figure 3: Suicide Attempts in Delaware by Sex (2001–2005)

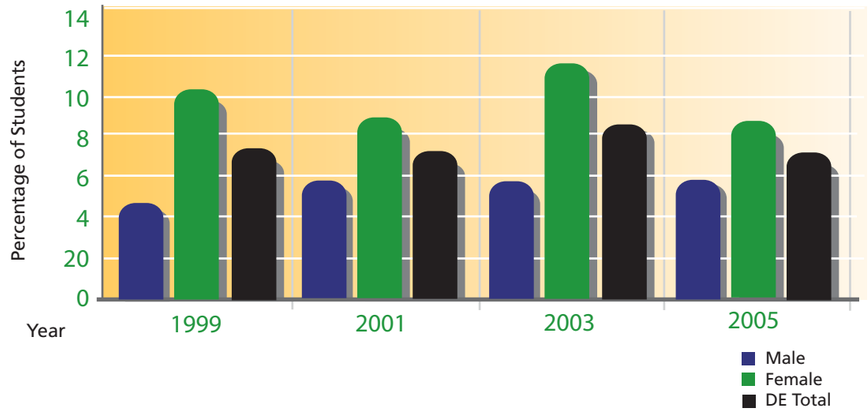


[9]Delaware Hospital Discharge Data. The data used in this section is all occurrence data (Delaware resident and non-resident).

For a typical high school classroom of 30 students, roughly four students on average seriously consider suicide.

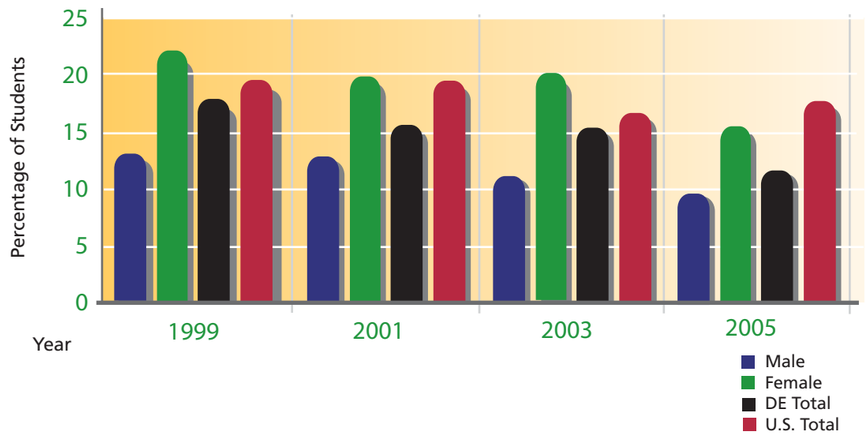
The percentage of high school students who seriously considered suicide in Delaware declined from 17.2% in 1999 to 12.7% in 2005. For a typical high school classroom of 30 students, this means that roughly four students on average seriously consider suicide.

Figure 4: Percentage of High School Students who Attempted Suicide by Gender (1999–2005)



Female high school students on average are one to two times more likely than male high school students to both consider suicide and attempt suicide.

Figure 5: Percentage of High School Students who Attempted Suicide by Gender (1999–2005)



For a typical high school classroom of 30 students, the data suggest that while four students on average will seriously consider suicide, at least one will attempt suicide during any given year.

[10]The data used in this section is from the Youth Risk Behavioral Survey (YRBS).

“Charlie was in emotional and spiritual pain.

When he was here, there was hope for him.

But then when he died,
there was no more hope.”

–Reverend Karen Moore

Karen Moore’s mother committed suicide when she was five. Her son, Charlie, committed suicide when he was 24 years old. He had tried before. But after apparently getting his life together and getting a new job, he hung himself. Karen has since devoted part of her life to facilitating survivor of suicide support groups.

Suicide Prevention Plan

Delaware is committed to developing a suicide prevention plan that reflects a public health, community-based approach to delivering effective services statewide. The public health approach to suicide prevention focuses on identifying the broader patterns of suicidal behavior through all age groups and populations, thus providing overlapping services across a life span. With great compassion, however, the Coalition restricts emphasis of the plan to the following at-risk groups in order to maximize the number of lives saved in the shortest time span:

- Youth, ages 10–24
- Middle-Aged Men, ages 25–50
- Elderly, ages 51 and above

Goals and Actions There are numerous goals and corresponding actions required for successful implementation of suicide prevention. To help maintain focus on priorities and to provide a limit to the resources necessary for plan execution in any given year, the plan encompasses a sequential, three-phased approach modeled after the National Suicide Prevention Plan:

PHASE ONE:

Goal 1: Promote Awareness that Suicide Is a Preventable Public Health Problem

YOUTH (AGES 10–24)

Objectives:	*Strategies:*
By 2009, establish regular suicide prevention coalition meetings designed to foster collaboration with stakeholders on prevention strategies across disciplines and with the public	Create relationships with relevant organizations Engage organizations in disseminating information through their channels of communication Encourage foundations and other stakeholders to support the Delaware Suicide Prevention Coalition Ensure Governor's endorsement and gain legislative support
By 2009, increase the number of both public and private organizations active in suicide prevention	Engage organizations in developing suicide prevention awareness messages and events
By 2010, design a public education campaign that increases public knowledge of suicide prevention to at least 50 percent of state's youth population	Convene Social Marketing Ad Hoc committee Complete a statewide social marketing plan Sponsor statewide conferences and special-issue forums on suicide and suicide prevention Create and disseminate the *Project LIFE* newsletter Advertise 1-800-273-TALK hotline number Use the National Suicide Prevention Lifeline Network for technical and material support Develop and implement a single web-based informational resource that provides information, support services and warning signs Develop and distribute suicide prevention toolkits

MIDDLE-AGED MEN

Objectives:	*Strategies:*
By 2009, establish regular suicide prevention coalition meetings designed to foster collaboration with stakeholders on prevention strategies across disciplines and with the public	Create relationships with organizations serving middle-aged men Engage organizations serving middle-aged men in disseminating information through their channels of communication Coordinate effective suicide prevention research and efforts for middle-aged men Encourage foundations and other stakeholders to support the Delaware Suicide Prevention Coalition Ensure Governor's endorsement and gain legislative support
By 2009, increase the number of both public and private organizations active in suicide prevention	Engage organizations in developing suicide prevention awareness messages and events
By 2010, design a public education campaign that increases public knowledge of suicide prevention to at least 50 percent of state's middle-aged male population	Convene Social Marketing Ad Hoc committee Complete a statewide social marketing plan Sponsor statewide conferences and special-issue forums on suicide and suicide prevention Create and disseminate the *Project LIFE* newsletter Advertise 1-800-273-TALK hotline number Use the National Suicide Prevention Lifeline Network for technical and material support Develop and implement a single web-based informational resource that provides information, support services and warning signs Develop and distribute suicide prevention toolkits

ELDERLY

Objectives:	*Strategies:*
By 2009, establish regular suicide prevention coalition meetings designed to foster collaboration with stakeholders on prevention strategies across disciplines and with the public	Create relationships with elderly and caregiver organizations, senior centers, assisted living facilities and nursing homes Engage senior-serving organizations in disseminating information through their channels of communication Coordinate effective suicide prevention research and efforts for seniors Encourage foundations and other stakeholders to support the Delaware Suicide Prevention Coalition Ensure Governor's endorsement and gain legislative support
By 2009, increase the number of both public and private organizations active in suicide prevention	Engage organizations in developing suicide prevention awareness messages and events

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ELDERLY CONT.

Objectives: cont.	*Strategies:* cont.
By 2010, design a public education campaign that increases public knowledge of suicide prevention to at least 50 percent of state's senior population	Convene Social Marketing Ad Hoc committee Complete a statewide social marketing plan Sponsor statewide conferences and special-issue forums on suicide and suicide prevention Create and disseminate the *Project LIFE* newsletter Advertise 1-800-273-TALK hotline number Use the National Suicide Prevention Lifeline Network for technical and material support Develop and implement a single web-based informational resource that provides information, support services and warning signs Develop and distribute suicide prevention toolkits

Goal 2: Develop Broad-Based Support for Suicide Prevention

YOUTH (AGES 10–24)

Objectives:	*Strategies:*
By 2010, establish a Youth Suicide Prevention Network (YSPN) to help implement the objectives of the Delaware Suicide Prevention Coalition statewide plan	Engage youth organizations dedicated to implementing the National Strategy as it pertains to creating the YSPN Convene quarterly to plan and implement community-based youth suicide prevention activities Provide technical assistance to members of the YSPN Engage relevant partners in suicide prevention activities
By 2010, establish public/private partnerships dedicated to implementing the National Strategy	Increase the number of government, professional, volunteer and other groups that integrate suicide prevention activities into their ongoing activities
By 2010, increase the number of state-organized faith-based communities adopting institutional policies promoting suicide prevention	Communicate with partners consistently to provide information and to increase involvement in suicide prevention projects
By 2010, increase the number of government, professional, volunteer and other groups that integrate suicide prevention activities into their ongoing activities	Encourage local faith-based groups to include suicide prevention as a topic of analysis and discussion Collaborate with faith-based groups to develop plans to assist their members in identifying risk factors, encouraging treatment for depression, increasing protective factors, and offering support and guidance to individuals Encourage local government, professional, volunteer and other groups to include suicide prevention as a topic of analysis and discussion in their programs Collaborate with government, professional, volunteer and other groups to develop suicide prevention activities that are included in their direct service programs, training workshops and other related activities

MIDDLE-AGED MEN

Objectives:	*Strategies:*
By 2010, establish public/private partnerships dedicated to implementing the National Strategy	Engage relevant partners in suicide prevention activities Increase the number of government, professional, volunteer and other groups that integrate suicide prevention activities into their ongoing activities Consistently communicate with partners to provide information and increase involvement in suicide prevention projects
By 2010, increase the number of state-organized faith-based communities adopting institutional policies promoting suicide prevention	Encourage local faith-based groups to include suicide prevention as a topic of analysis and discussion Collaborate with faith-based groups to develop plans to assist their members in identifying risk factors, encouraging treatment for depression, increasing protective factors, and offering support and guidance to middle-aged men
By 2010, increase the number of government, professional, volunteer and other groups that integrate suicide prevention activities into their ongoing activities	Encourage local government, professional, volunteer and other groups to include suicide prevention as a topic of analysis and discussion in their programs Collaborate with government, professional, volunteer and other groups to develop suicide prevention activities that are included in their direct service programs, training workshops and other related activities Integrate suicide prevention activities in programs offered by law enforcement, military organizations, Employment Assistance Programs (EAP), volunteer organizations, sports, hobby and recreational groups, churches, and pharmaceutical companies

ELDERLY

Objectives:	*Strategies:*
By 2010, establish public/private partnerships dedicated to implementing the National Strategy	Engage relevant partners in suicide prevention activities Increase the number of government, professional, volunteer and other groups that integrate suicide prevention activities into their ongoing activities Consistently communicate with partners to provide information and increase involvement in suicide prevention projects
By 2010, increase the number of state-organized faith-based communities adopting institutional policies promoting suicide prevention	Encourage local faith-based groups to include suicide prevention as a topic of analysis and discussion Collaborate with faith-based groups to develop plans to assist their members in identifying risk factors, encouraging treatment for depression, increasing protective factors, and offering support and guidance to individuals

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ELDERLY CONT.

Objectives: cont.	*Strategies:* cont.
By 2010, increase the number of government, professional, volunteer and other groups that integrate suicide prevention activities into their ongoing activities	Encourage local government, professional, volunteer and other groups to include suicide prevention as a topic of analysis and discussion in their programs Collaborate with government, professional, volunteer and other groups to develop suicide prevention activities that are included in their direct service programs, training workshops and other related activities Integrate suicide prevention activities in programs offered by law enforcement, long-term care facilities, nursing homes, senior centers, retired military organizations and pharmaceutical companies

Goal 3: Develop and Implement Reduction Strategies for the Stigma Associated with Consumers of Mental Health, Substance Abuse and Suicide Prevention Services

YOUTH (AGES 10–24)

Objectives:	*Strategies:*
By 2011, increase the number of youth that view mental and physical health as equal and inseparable components of overall health	Publish related articles in *Project LIFE* newsletter Disseminate articles and public service announcements that educate about and highlight youth suicide prevention strategies Develop public awareness campaigns to transform public attitudes and build on existing efforts Enhance school health curricula to ensure that mental health and substance abuse are appropriately addressed
By 2011, increase the number of individuals who view youth mental heath disorders as real illnesses that respond to specific courses of treatment	Disseminate related articles to the public that educate about and highlight youth suicide prevention strategies Collaborate with medical professionals to reduce the stigma within the medical community and to encourage patients to seek mental health treatment Provide information to the pediatric and primary health care community to educate them about the signs, symptoms and available resources regarding suicide for youth and their families Support educational campaigns that help youth understand how brain research has contributed to the understanding of mental illness
By 2011, increase the number of individuals who view consumers of mental health, substance abuse and suicide prevention services as pursuing fundamental care and treatment for overall health	Develop public service announcements depicting consumers of mental health and substance abuse services as exhibiting responsible and appropriate health care behavior
By 2011, increase the number of those suicidal persons with underlying disorders who receive appropriate mental health treatment	Develop public awareness campaigns to transform public attitudes regarding stigma related to mental health disorders Develop a public information campaign describing the role of medication in the treatment of persons with mental or substance use disorders (such as bipolar disorder, schizophrenia, dual diagnosis) Collaborate with local and state agencies to decrease barriers for ethnic and cultural groups such as lack of health insurance

MIDDLE-AGED MEN

Objectives:	*Strategies:*
By 2011, increase the number of middle-aged men who view mental and physical health as equal and inseparable components of overall health	Publish related articles in *Project LIFE* newsletter Disseminate articles and public service announcements that educate about and highlight middle-aged male suicide prevention strategies Develop public awareness campaigns to transform public attitudes and build on existing efforts Enhance health curriculums and workshops to ensure that mental health and substance abuse are appropriately addressed
By 2011, increase the number of middle-aged men who view mental health disorders as real illnesses that respond to specific courses of treatment	Disseminate related articles to the public that educate and highlight suicide prevention strategies especially during holidays and anniversaries Collaborate with medical professionals to reduce the stigma within the community and to encourage patients to seek mental health treatment Provide information to the primary health care community to educate them about the signs, symptoms and available resources regarding suicide for middle-aged men and their families Support educational campaigns that help middle-aged men understand how brain research has contributed to the understanding of mental illness
By 2011, increase the number of middle-aged men who view consumers of mental health, substance abuse and suicide prevention services as pursuing fundamental care and treatment for overall health	Develop public service announcements depicting consumers of mental health and substance abuse services as exhibiting responsible and appropriate health care behavior
By 2011, increase the number of middle-aged men with suicidal ideation and underlying disorders who receive appropriate mental health treatment	Develop public awareness campaigns to transform public attitudes regarding stigma related to mental health disorders Develop a public information campaign describing the role of medication in the treatment of persons with mental or substance use disorders (such as bipolar disorder, schizophrenia, dual diagnosis) Collaborate with local and state agencies to decrease barriers for ethnic and cultural groups such as lack of health insurance

ELDERLY

Objectives:	*Strategies:*
By 2011, increase the number of seniors who view mental and physical health as equal and inseparable components of overall health	Publish related articles in *Project LIFE* newsletter Disseminate articles and public service announcements that educate about and highlight senior suicide prevention strategies Develop public awareness campaigns to transform public attitudes and build on existing efforts Enhance health curriculums and senior workshops to ensure that mental health and substance abuse are appropriately addressed

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ELDERLY CONT.

Objectives: *cont.*	*Strategies:* *cont.*
By 2011, increase the number of individuals who view senior mental health disorders as real illnesses that respond to specific courses of treatment	Disseminate related articles to the public that educate and highlight senior suicide prevention strategies especially during holidays and anniversaries Collaborate with medical professionals to reduce the stigma within the medical community and to encourage patients to seek mental health treatment Provide information to the primary health care community to educate them about the signs, symptoms and available resources regarding suicide for seniors and their families Support educational campaigns that help seniors understand how brain research has contributed to the understanding of mental illness
By 2011, increase the number of individuals who view consumers of mental health, substance abuse and suicide prevention services as pursuing fundamental care and treatment for overall health	Develop public service announcements depicting consumers of mental health and substance abuse services as exhibiting responsible and appropriate health care behavior
By 2011, increase the number of those suicidal persons with underlying disorders who receive appropriate mental health treatment	Develop public awareness campaigns to transform public attitudes regarding stigma related to mental health disorders Develop a public information campaign describing the role of medication in the treatment of persons with mental or substance use disorders (such as bipolar disorder, schizophrenia, dual diagnosis) Collaborate with local and state agencies to decrease barriers for ethnic and cultural groups such as lack of health insurance

Goal 4: Develop, Implement and Evaluate Suicide Prevention Programs

YOUTH (AGES 10–24)

Objectives:	*Strategies:*
By 2011, increase the number of agencies and organizations with comprehensive suicide prevention plans that coordinate across government agencies	Collaborate and coordinate with local agencies that deliver services in public health (injury prevention, mental health and substance abuse) Conduct a gap analysis that includes collection of data from each program agency that provides direct treatment services, information, education and environment-related services Assist agencies and organizations in developing goals, objectives, timetables and actions to be taken Provide agencies and organizations with national and state resources related to evidence-based programming for youth suicide prevention Ensure that all plans are culturally competent according to the guidelines and criteria developed by the Cultural Competence Ad Hoc committee

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YOUTH (AGES 10–24) CONT.

Objectives: *cont.*	*Strategies:* *cont.*
By 2011, increase the number of school districts and private school associations with best practices and evidence-based programs designed to address serious childhood and adolescent distress and prevent suicide	Provide training and technical assistance in best practices and evidence-based programs (e.g., SOS, Teen Screen, peer-to-peer leadership program) Ensure that all school districts and private school associations are following the fidelity guidelines to achieve the program outcomes Develop criteria by which the program can be evaluated
By 2011, increase the number of colleges and universities with best practices and evidence-based programs designed to address serious young adult distress and prevent suicide	Provide training and technical assistance in evidence-based programs (e.g., Campus Connect) Ensure that all colleges and universities are following the fidelity guidelines to achieve the program outcomes Develop criteria by which the program can be evaluated
By 2011, increase the number of correctional institutions and detention centers housing either juvenile or adult offenders, with best practices and evidence-based suicide prevention programs	Provide training and technical assistance in evidence-based programs (e.g., safeTALK) Ensure that correctional institutions and detention centers are following the fidelity guidelines to achieve the program outcomes Develop criteria by which the program can be evaluated
By 2011, increase the number of youth who are served in the Child Development Community Policing Program	Expand the Child Development Community Policing Program to reach youth and families who have experienced trauma
By 2011, increase the number of youth who use web-based components, the Contact Lifeline Suicide Prevention Hotline and the Division of Child Mental Health Services	Develop a freestanding website for Delaware youth suicide prevention Advertise 1-800-273-TALK hotline number on the Delaware youth suicide prevention website Advertise the Division of Child Mental Health Services, contact numbers and youth resources on the Delaware youth suicide prevention website
By 2011, develop an improved data collection plan that regularly obtains and analyzes state and county suicide rates and suicide attempts in a coordinated and integrated method	Evaluate state-level achievements based on established National Outcome Measures (NOM) Define the goals and objectives of the data collection protocol Agree on operational definitions and methodology for the statewide data collection plan Ensure data collection (and measurement) repeatability, reproducibility, accuracy and stability in activities Follow through with the data collection process as defined by the statewide data collection plan

MIDDLE-AGED MEN

Objectives:	*Strategies:*
By 2011, increase the number of agencies and organizations with comprehensive suicide prevention plans that coordinate across government agencies	Collaborate and coordinate with local agencies that deliver services in public health (mental health and substance abuse) Conduct a gap analysis that includes collection of data from each program agency that provides direct treatment services, information, education and environment-related services Assist agencies and organizations in developing goals, objectives, timetables and actions to be taken Provide agencies and organizations with national and state resources related to developing best practices for middle-aged male suicide prevention Ensure that all plans are culturally competent according to the guidelines and criteria developed by the Cultural Competence Ad Hoc committee
By 2011, increase the number of programs with best practices and evidence-based programs designed to address serious mental health distress among middle-aged men	Provide training and technical assistance in best practices and evidence-based programs Ensure that all programs and associations are following the fidelity guidelines to achieve the program outcomes Develop criteria by which the program can be evaluated
By 2011, increase the number of correctional institutions with best practices and evidence-based suicide prevention programs	Provide training and technical assistance in evidence-based programs Ensure that correctional institutions are following the fidelity guidelines to achieve the program outcomes Develop criteria by which the program can be evaluated
By 2011, increase the number of middle-aged men who use web-based components with suicide prevention resources	Develop a freestanding website for Delaware middle-aged male suicide prevention Advertise 1-800-273-TALK hotline number on the Delaware middle-aged male suicide prevention website Advertise the Division of Substance Abuse and Mental Health Services and other resources on the Delaware middle-aged male suicide prevention website
By 2011, develop an improved data collection plan that regularly obtains and analyzes state and county suicide rates and suicide attempts in a coordinated and integrated method	Evaluate state-level achievements based on established National Outcome Measures (NOM) Define the goals and objectives of the data collection protocol Agree on operational definitions and methodology for the statewide data collection plan Ensure data collection (and measurement) repeatability, reproducibility, accuracy and stability in activities Follow through with the data collection process as defined by the statewide data collection plan

ELDERLY

Objectives:	*Strategies:*
By 2011, increase the number of agencies and organizations with comprehensive suicide prevention plans that coordinate across government agencies	Collaborate and coordinate with local agencies that deliver services in public health (injury prevention, mental health and substance abuse) Conduct a gap analysis that includes collection of data from each program agency that provides direct treatment services, information, education and environment-related services Assist agencies and organizations in developing goals, objectives, timetables and actions to be taken Provide agencies and organizations with national and state resources related to evidence-based programming for senior suicide prevention Ensure that all plans are culturally competent according to the guidelines and criteria developed by the Cultural Competence Ad Hoc committee
By 2011, increase the number of senior centers and senior-serving programs with best practices and evidence-based programs designed to address serious mental health distress in the elderly	Provide training and technical assistance in best practices and evidence-based programs such as Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT) Ensure that all senior centers and senior-serving programs and associations are following the fidelity guidelines to achieve the program outcomes Develop criteria by which the program can be evaluated
By 2011, increase the number of correctional institutions with best practices and evidence-based suicide prevention programs	Provide training and technical assistance in evidence-based programs Ensure that correctional institutions are following the fidelity guidelines to achieve the program outcomes Develop criteria by which the program can be evaluated
By 2011, increase the number of seniors who use web-based components, the Division of Aging Services and the Division of Substance Abuse and Mental Health	Develop a freestanding Delaware senior suicide prevention website Advertise 1-800-273-TALK hotline number on the Delaware senior suicide prevention website Advertise the Division of Substance Abuse and Mental Health Services, Division of Aging Services and other senior-serving resources on the Delaware senior suicide prevention website
By 2011, develop an improved data collection plan that regularly obtains and analyzes state and county suicide rates and suicide attempts in a coordinated and integrated method	Evaluate state-level achievements based on established National Outcome Measures (NOM) Define the goals and objectives of the data collection protocol Agree on operational definitions and methodology for the statewide data collection plan Ensure data collection (and measurement) repeatability, reproducibility, accuracy and stability in activities Follow through with the data collection process as defined by the statewide data collection plan

PHASE TWO:

Goal 5: Identify and Implement Education, Training and Outreach to Enhance Identification of At-Risk Behavior and Treatment Delivery

YOUTH (AGES 10–24)

Objectives:	*Strategies:*
By 2012, increase the number of professionals who include training in the assessment and management of suicide risk, and the identification and promotion of protective factors	Teach agencies and organizations to incorporate evidence-based training of professional staff in programs
By 2012, increase the number of clergy who have received gatekeeper training in identifying and responding to suicide risk and behaviors and the differentiation of mental disorders and faith crises	Engage clergy and faith-based communities regarding Applied Suicide Intervention Skills Training (ASIST), Question Persuade Refer (QPR) Training and other gatekeeper training Provide training and technical assistance to clergy Implement gatekeeper training methods and techniques in faith-based communities
By 2012, increase the number of educational faculty and staff who have received gatekeeper training in identifying and responding to children and adolescents at risk for suicide	Encourage educational faculty and staff to receive gatekeeper training (e.g., safeTALK) Provide training and technical assistance to educational faculty and staff Implement gatekeeper training methods and techniques in public and private schools
By 2012, increase the number of education programs available to family members and community members in close relationships with youth	Organize and integrate public awareness workshops in locations (school meetings, libraries, churches) convenient for families and community members
By 2012, increase the number of juvenile justice workers who have received training in identifying and responding to persons at risk for suicide	Encourage juvenile justice workers to receive gatekeeper training (e.g., safeTALK) Provide training and technical assistance to juvenile justice workers Implement gatekeeper training methods and techniques in juvenile justice facilities
By 2012, increase the number of university and college staff who have received training in identifying and responding to persons at risk for suicide	Engage Delaware university and college staffs to receive gatekeeper training (e.g., Campus Connect) Provide training and technical assistance to university and college staffs Implement suicide prevention programs in universities and colleges throughout Delaware

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YOUTH (AGES 10–24) CONT.

Objectives: cont.	*Strategies: cont.*
By 2012, increase the number of family members who receive support and education in the care of youth with mental health and substance abuse disorders	Create new support groups in psychiatric and medical facilities, high school wellness centers, community organizations and faith-based communities Promote the existence of support groups on the Delaware youth suicide prevention website and other communication media Ensure the promotion of support groups by state, local and community-based agencies
By 2012, increase the number of suicide survivors who are attending educational and support programs	Promote available support groups Create new support groups in psychiatric and medical facilities, high school wellness centers, community organizations and faith-based communities

MIDDLE-AGED MEN

Objectives:	*Strategies:*
By 2012, increase the number of professionals who include training in the assessment and management of suicide risk, and the identification and promotion of protective factors	Teach agencies and organizations to incorporate evidence-based gatekeeper training
By 2012, increase the number of clergy who have received gatekeeper training in identifying and responding to suicide risk and behaviors and the differentiation of mental disorders and faith crises	Contact clergy and faith-based communities regarding Applied Suicide Intervention Skills Training (ASIST), Question Persuade Refer (QPR) Training and other gatekeeper training Provide training and technical assistance to clergy Implement gatekeeper training methods and techniques in faith-based communities
By 2012, increase the number of education programs available to family members and community members in close relationships with middle-aged men	Organize and integrate public awareness workshops in locations such as medical facilities, libraries, churches and worksites convenient for families and community members Provide training, workshops and seminars to educators serving middle-aged men
By 2012, increase the number of correctional workers who have received training on identifying and responding to persons at risk for suicide	Contact and engage correctional workers in a specialized middle-aged male training program Provide training and technical assistance to correctional workers in best practice programs
By 2012, increase the number of family members who receive support and education in mental health and substance abuse issues common among middle-aged men	Create new support and education groups in psychiatric and medical facilities, worksites, community organizations and faith-based communities Publicize the existence of support and education groups on the Delaware middle-aged male suicide prevention website and other communication media Ensure the promotion of support and education groups by state, local and community-based agencies
By 2012, increase the number of suicide survivors who are attending educational and support programs	Promote available support groups Create new support groups in psychiatric and medical facilities, military organizations, community organizations and faith-based communities

ELDERLY

Objectives:	*Strategies:*
By 2012, increase the number of professionals who include training in the assessment and management of suicide risk, and the identification and promotion of protective factors	Teach senior-serving agencies and organizations to incorporate evidence-based gatekeeper training
By 2012, increase the number of clergy who have received ASIST training in identifying and responding to suicide risk and behaviors and the differentiation of mental disorders and faith crises	Contact clergy and faith-based communities regarding Applied Suicide Intervention Skills Training (ASIST), Question Persuade Refer (QPR) Training and other gatekeeper training Provide training and technical assistance to clergy Implement gatekeeper training methods and techniques in faith-based communities
By 2012, increase the number of education programs available to caretakers, family members and community members in close relationships with seniors	Organize and integrate public awareness workshops in locations such as medical facilities, senior centers, nursing homes, libraries, churches convenient for families and community members Provide training, workshops and seminars to educators serving seniors
By 2012, increase the number of correctional workers who have received training on identifying and responding to persons at risk for suicide	Contact and engage correctional workers in a specialized senior training program Provide training and technical assistance to correctional workers in best practice programs (e.g., PROSPECT)
By 2012, increase the number of family members and caretakers who receive support and education in the care of seniors with mental health and substance abuse disorders	Create new support and education groups in psychiatric and medical facilities, senior centers, nursing homes, community organizations and faith-based communities Publicize the existence of support and education groups on the Delaware senior suicide prevention website and other communication media Ensure the promotion of support and education groups by state, local and community-based agencies
By 2012, increase the number of suicide survivors who are attending educational and support programs	Promote available support groups Create new support groups in psychiatric and medical facilities, nursing homes and senior centers, retirement support groups, community organizations and faith-based communities

Goal 6: Develop and Promote Effective Clinical and Professional Practices

YOUTH (AGES 10–24)

Objectives:	*Strategies:*
By 2012, increase the number of patients treated for self-destructive behavior in emergency departments and hospital settings that pursue the proposed mental health follow-up plan	Develop guidelines for hospitals and health delivery systems that ensure adequate resources to confirm mental health follow-up appointments Collaborate locally to establish processes that increase the number of patients who keep follow-up mental health appointments after discharge from emergency departments and other hospital settings Ensure that a guardian of the youth patient receives the proposed mental health follow-up plan

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YOUTH (AGES 10–24) CONT.

Objectives: cont.	*Strategies: cont.*
By 2012, start using standardized guidelines for assessment of suicide risk among youth receiving care in primary health care settings, emergency departments, and specialty mental health and substance abuse treatment centers	Develop standardized suicide assessment guidelines Identify those who need training and technical assistance in using suicide assessment guidelines Provide training and technical assistance to personnel in primary health care settings, emergency departments, and specialty mental health and substance abuse treatment centers Promote effective assessment services to personnel in primary health care settings, emergency departments, and specialty mental health and substance abuse treatment centers
By 2012, increase the number of providers of key services to suicide survivors who have received training that addresses their own exposure to suicide and the unique needs of suicide survivors	Provide training and technical assistance in suicide survival to professionals and other service-oriented individuals (e.g., emergency medical technicians, firefighters, law enforcement officers, funeral directors and clergy) Arrange for suicide survivors to speak at seminars on topics such as recognizing and managing the personal impact of suicide to first responders Disseminate the toolkit to professionals and other service-oriented individuals
By 2012, increase the number of hospital emergency departments that routinely provide immediate post-trauma psychological support and mental health education for all victims of sexual assault and/or physical abuse	Develop protocols to provide post-trauma psychological support and mental health education for young patients Ensure proper follow-up and after-care treatment for young patients Disseminate the toolkit to hospital emergency departments
By 2012, develop and implement groups for providing education to family members of youths receiving care for the treatment of mental health and substance abuse disorders with risk of suicide in facilities	Develop protocols for screening personnel to provide consistent education to family members Educate family members about how to watch for changes in mood and behavior Educate family members on how to access help to ensure that youth do not become self-destructive

MIDDLE-AGED MEN

Objectives:	*Strategies:*
By 2012, increase the number of patients treated for self-destructive behavior in emergency departments and hospital settings that pursue the proposed mental health follow-up plan	Develop guidelines for hospitals and health delivery systems that ensure adequate resources to confirm mental health follow-up appointments Collaborate locally to establish processes that increase the number of patients who keep follow-up mental health appointments after discharge from emergency departments and other hospital settings Ensure that a guardian of the middle-aged male patient receives the proposed mental health follow-up plan

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MIDDLE-AGED MEN CONT.

Objectives: cont.	*Strategies:* cont.
By 2012, start using standardized guidelines for assessment of suicide risk among middle-aged men receiving care in primary health care settings, emergency departments, military hospitals, specialty mental health and substance abuse treatment centers	Develop standardized suicide assessment guidelines Identify those who need training and technical assistance in using suicide assessment guidelines Provide training and technical assistance to personnel in primary health care settings, emergency departments, military hospitals, and specialty mental health and substance abuse treatment centers Promote effective assessment services to personnel in primary health care settings, emergency departments, military hospitals, and specialty mental health and substance abuse treatment centers
By 2012, increase the number of those who provide key services to suicide survivors who have received training that addresses their own exposure to suicide and the unique needs of suicide survivors	Provide training and technical assistance in suicide survival to professionals and other service-oriented individuals (e.g., emergency medical technicians, firefighters, EAP, law enforcement officers, funeral directors, clergy) Arrange for suicide survivors to speak at seminars on topics such as recognizing and managing the personal impact of suicide to first responders Disseminate the toolkit to professionals and other service-oriented individuals
By 2012, increase the number of hospital emergency departments that routinely provide immediate post-trauma psychological support and mental health education for all victims of sexual assault and/or physical abuse	Develop protocols for screening to provide post-trauma psychological support and mental health education for middle-aged male patients Ensure proper follow-up and after-care treatment for middle-aged male patients Disseminate the toolkit to hospital emergency departments
By 2012, develop and implement groups for providing education to family members of middle-aged men receiving care for the treatment of mental health and substance abuse disorders with risk of suicide in facilities	Develop protocols for screening personnel to provide consistent education to family members Educate family members about how to watch for changes in mood and behavior Educate family members on how to access help to ensure that middle-aged men do not become self-destructive

ELDERLY

Objectives:	*Strategies:*
By 2012, increase the number of patients treated for self-destructive behavior in emergency departments and hospital settings who pursue the proposed mental health follow-up plan	Develop guidelines for hospitals and health delivery systems that ensure adequate resources to confirm mental health follow-up appointments Collaborate locally to establish processes that increase the number of patients who keep follow-up mental health appointments after discharge from emergency departments and hospital settings Ensure that a guardian of the elderly patient receives the proposed mental health follow-up plan

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ELDERLY CONT.

Objectives: cont.	*Strategies:* cont.
By 2012, start using standardized guidelines for assessment of suicide risk among seniors receiving care in primary health care settings, emergency departments, senior centers, nursing homes, and specialty mental health and substance abuse treatment centers	Develop standardized suicide assessment guidelines Identify those who need training and technical assistance in using suicide assessment guidelines Provide training and technical assistance to personnel in primary health care settings, emergency departments, senior centers, nursing homes, and specialty mental health and substance abuse treatment centers Promote effective assessment services to personnel in primary health care settings, emergency departments, senior centers, nursing homes and specialty mental health and substance abuse treatment centers
By 2012, increase the number of those who provide key services to suicide survivors who have received training that addresses their own exposure to suicide and the unique needs of suicide survivors	Provide training and technical assistance in suicide survival to professionals and other service-oriented individuals (e.g., emergency medical technicians, firefighters, senior center staff, nursing home personnel, law enforcement officers, funeral directors, clergy) Arrange for suicide survivors to speak at seminars on topics such as recognizing and managing the personal impact of suicide to first responders Disseminate the toolkit to professionals and other service-oriented individuals
By 2012, increase the number of hospital emergency departments that routinely provide immediate post-trauma psychological support and mental health education for all victims of sexual assault and/or physical abuse	Develop protocols for screening to provide post-trauma psychological support and mental health education for senior patients Ensure proper follow-up and after-care treatment for senior patients Disseminate the toolkit to hospital emergency departments
By 2012, develop and implement groups for providing education to family members of seniors receiving care for the treatment of mental health and substance abuse disorders with risk of suicide in facilities	Develop protocols for screening personnel to provide consistent education to family members Educate family members about how to watch for changes in mood and behavior Educate family members on how to access help to ensure that seniors do not become self-destructive

Goal 7: Improve Integration between Consumers, Community, Providers, Organizations and Funding Sources

YOUTH (AGES 10–24)

Objectives:	*Strategies:*
By 2012, increase the number of health insurance plans to cover mental health and substance abuse services on par with coverage for physical health	Establish connections with groups (Delaware Psychological Association, Medical Society, etc.) and support their advocacy efforts
By 2012, implement utilization management guidelines for suicidal risk in managed care and insurance plans	Review and consolidate existing guidelines as appropriate

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YOUTH (AGES 10–24) CONT.

Objectives: cont.	*Strategies:* cont.
By 2012, integrate mental health and suicide prevention into health and social services outreach programs for at-risk youth populations	Conduct a gap analysis of health and social services outreach programs Leverage existing resources to maximize state funding and seek additional funding as necessary Develop outreach programs to help youth access and follow up with care
By 2012, define and implement screening guidelines for schools, colleges and juvenile justice system, along with guidelines on linkages with service providers	Research Best Practices and existing guidelines Include assessment tools and criteria, protocols, algorithms for assessing risk status, referral guidelines and evaluation measures in mental health and substance abuse screening
By 2012, define state guidelines for effective comprehensive support programs for youth suicide survivors	Develop guidelines and offer peer leadership training for facilitators of suicide survivors support groups
By 2012, develop quality care/utilization management guidelines for effective response to suicidal risk or behavior and implement these guidelines in managed care and health insurance plans	Collaborate with managed care and insurance providers to develop uniform operational definitions for suicidal behaviors and related terms in quality care/utilization management guidelines

MIDDLE-AGED MEN

Objectives:	*Strategies:*
By 2012, increase the number of health insurance plans to cover mental health and substance abuse services on par with coverage for physical health	Establish connections with groups (Delaware Psychological Association, Medical Society) and support their advocacy efforts
By 2012, implement utilization management guidelines for suicidal risk in managed care and insurance plans	Review and consolidate existing guidelines that deal with middle-aged suicide Provide insurance companies with toolbox materials
By 2012, integrate mental health and suicide prevention into health and social services outreach programs for at-risk middle-aged populations	Conduct gap analysis of health and social services outreach programs Leverage existing resources to maximize state funding and seek additional funding as necessary Develop outreach programs to help middle-aged men access and follow up with care
By 2012, define and implement screening guidelines for correctional institutions	Research existing guidelines on handling middle-aged suicides and adopt best practice models Include assessment tools and criteria, protocols, algorithms for assessing risk status, referral guidelines and evaluation measures in mental health and substance abuse screening
By 2012, define state guidelines for effective comprehensive support programs for middle-aged male suicide survivors	Develop guidelines and offer peer leadership training for facilitators of suicide survivors support groups
By 2012, develop and implement quality care/utilization management guidelines for effective response to suicidal risk or behavior	Collaborate with managed care and insurance providers to develop uniform operational definitions for suicidal behaviors and related terms in quality care/utilization management guidelines

ELDERLY

Objectives:	*Strategies:*
By 2012, increase the number of health insurance plans to cover mental health and substance abuse services on par with coverage for physical health	Establish connections with groups (Delaware Psychological Association, Medical Society, Medicare and Medicaid) and support their advocacy efforts
By 2012, implement utilization management guidelines for suicidal risk in managed care and insurance plans	Review and consolidate existing guidelines that deal with elderly suicide Provide insurance companies, Medicare and Medicaid providers with toolbox materials
By 2012, integrate mental health and suicide prevention into health and social services outreach programs for at-risk elderly populations	Conduct a gap analysis of health and social services outreach programs Leverage existing resources to maximize state funding and seek additional funding as necessary Develop outreach programs to help seniors access and follow up with care Integrate the Division of Services of Aging and Adults with Physical Disabilities and other senior-oriented groups into collaborations to promote awareness
By 2012, define and implement screening guidelines for senior centers, nursing facilities, retired military facilities and correctional institutions	Research existing guidelines on handling elderly suicides and adopt best practice models Include assessment tools and criteria, protocols, algorithms for assessing risk status, referral guidelines, and evaluation measures in mental health and substance abuse screening
By 2012, define state guidelines for effective comprehensive support programs for elderly suicide survivors	Develop guidelines and offer peer leadership training for facilitators of suicide survivors support groups
By 2012, develop and implement quality care/utilization management guidelines for effective response to suicidal risk or behavior	Collaborate with managed care and insurance providers to develop uniform operational definitions for suicidal behaviors and related terms in quality care/utilization management guidelines

Goal 8: Improve Portrayals of Suicidal Behavior, Mental Illness and Substance Abuse in the Entertainment and News Media

YOUTH (AGES 10–24)

Objectives:	*Strategies:*
By 2012, establish a public/private group designed to promote the responsible representation of suicidal behaviors and mental illness in the media	Convene a group that includes representatives from the state Public Communications Officers, the *News Journal*, CN8, local TV channels 22 and 8, and other affiliates of the Delaware Suicide Prevention Coalition (DSPC) Develop guidelines for the responsible portrayal and reporting of suicides and suicide attempts in media and entertainment outlets

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YOUTH (AGES 10–24) CONT.

Objectives: cont.	*Strategies:* cont.
By 2012, increase the number of journalism departments in local colleges and universities that adequately address reporting of mental illness and suicide in their curricula	Convene a group that includes representatives from journalism departments in local colleges and universities and the Division of Child Mental Health Services (DCMHS), as well as liaisons to the DSPC liaison and other affiliates of the DSPC Promote education on responsible reporting and encourage instruction on targeting stories using the reporting guidelines
By 2012, increase the number of television programs and news reports that observe recommended guidelines in the depiction of suicide and mental illness	Promote responsible reporting in all media outlets Establish contact persons for the media and conduct regular follow-up regarding responsible reporting of suicide and mental health issues Disseminate guidelines for reporting mental illness

MIDDLE-AGED MEN

Objectives:	*Strategies:*
By 2012, establish a public/private group designed to promote the responsible representation of suicidal behaviors and mental illness in the media	Convene a group that includes the state Public Communications Officers, the *News Journal*, CN8, local TV channels 22 and 8, and other affiliates of the Delaware Suicide Prevention Coalition (DSPC) Develop guidelines for the responsible portrayal and reporting of suicides and suicide attempts in media and entertainment outlets
By 2012, increase the number of journalism departments in local colleges and universities that adequately address reporting of mental illness and suicide in middle-aged men	Convene a group that includes representatives from journalism departments in local colleges and universities, as well as liaisons to the DSPC and other affiliates of the DSPC Promote education on the responsible reporting and encourage instruction on targeting stories using the reporting guidelines
By 2012, increase the number of television programs and news reports that observe recommended guidelines in the depiction of suicide and mental illness in middle-aged men	Promote responsible reporting in all media outlets Establish contact persons for the media and conduct regular follow-up regarding responsible reporting of suicide and mental health issues Disseminate guidelines for reporting mental illness

ELDERLY

Objectives:	*Strategies:*
By 2012, establish a public/private group designed to promote the responsible representation of suicidal behaviors and mental illness in the media	Convene a group that includes the state Public Communications Officers, the *News Journal*, CN8, local TV channels 22 and 8, and other affiliates of the Delaware Suicide Prevention Coalition (DSPC) Develop guidelines for the responsible portrayal and reporting of suicides and suicide attempts in media and entertainment outlets

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ELDERLY CONT.

Objectives: cont.	*Strategies:* cont.
By 2012, increase the number of journalism departments in local colleges and universities that adequately address reporting of mental illness and suicide in the elderly	Convene a group that includes representatives from journalism departments in local colleges and universities and the Division of Services of Aging and Adults with Physical Disabilities, as well as liaisons to the DSPC and other affiliates of the DSPC Promote education on responsible reporting and encourage instruction on targeting stories using the reporting guidelines
By 2012, increase the number of television programs and news reports that observe recommended guidelines in the depiction of suicide and mental illness in the elderly	Promote responsible reporting in all media outlets Establish contact persons for the media and conduct regular follow-up regarding responsible reporting of suicide and mental health issues Disseminate guidelines for reporting mental illness

PHASE THREE:

Goal 9: Promote Efforts to Reduce Access to Lethal Means and Methods of Self-Harm

YOUTH (AGES 10–24)

Objectives:	*Strategies:*
By 2015, increase the number of primary care clinicians, other health care providers, and health and safety officials who routinely assess the presence of lethal means (including firearms, drugs, carbon monoxide and poisons) in the home and educate about actions to reduce associated risks	Develop a screening tool for primary care clinicians, other health care providers, and health and safety officials to assess the presence of lethal means in the home Develop guidelines on how to talk to parents about the presence of lethal means in the home Educate youth and families about firearm storage and access, and about appropriate storage of alcoholic beverages, prescription drugs, over-the-counter medications and poisons used for household purposes
By 2015, expose a large number of households to public information campaigns designed to reduce accessibility of lethal means	Educate parents and youth about limiting access to lethal means Use multiple strategies to communicate the message through posters and pamphlets, videos, bus signs and billboards, and other media
By 2015, advocate for firearm safety, safer methods for dispensing potentially lethal quantities of medications and methods for reducing carbon monoxide poisoning from automobile exhaust systems	Support and sponsor legislative efforts in the improvement of technologies to prevent youth suicide by lethal means Remain knowledgeable of current topics and support national advocacy efforts in this area

MIDDLE-AGED MEN

Objectives:	*Strategies:*
By 2015, increase the number of primary care clinicians, other health care providers, and health and safety officials who routinely assess the presence of lethal means (including firearms, drugs, carbon monoxide and poisons) in the home and educate about actions to reduce associated risks	Develop a screening tool for primary care clinicians, other health care providers, and health and safety officials to assess the presence of lethal means in the home Develop guidelines on how to talk to family members and caregivers about the presence of lethal means in the home Educate families and caregivers about firearm storage and access, carbon monoxide poisoning, appropriate storage of alcoholic beverages, prescription drugs, over-the-counter medications, and poisons used for household purposes
By 2015, expose a large number of households to public information campaigns designed to reduce accessibility of lethal means	Educate families and caregivers about limiting access to lethal means Use multiple strategies to communicate the message through posters and pamphlets, videos, bus signs and billboards, and other media
By 2015, advocate for firearm safety, safer methods for dispensing potentially lethal quantities of medications and methods for reducing carbon monoxide poisoning from automobile exhaust systems	Support and sponsor legislative efforts in the improvement of technologies to prevent middle-aged suicide by lethal means Remain knowledgeable of current topics and support national advocacy efforts in this area

ELDERLY

Objectives:	*Strategies:*
By 2015, increase the number of primary care clinicians, other health care providers, and health and safety officials who routinely assess the presence of lethal means (including firearms, drugs, carbon monoxide and poisons) in the home and educate about actions to reduce associated risks	Develop a screening tool for primary care clinicians, other health care providers, and health and safety officials to assess the presence of lethal means in the home Develop guidelines on how to talk to family members and caregivers about the presence of lethal means in the home Educate families and caregivers about firearm storage and access, carbon monoxide poisoning, appropriate storage of alcoholic beverages, prescription drugs, over-the-counter medications, and poisons used for household purposes
By 2015, expose a large number of households to public information campaigns designed to reduce accessibility of lethal means	Educate families and caregivers about limiting access to lethal means Use multiple strategies to communicate the message through posters and pamphlets, videos, bus signs and billboards, and other media
By 2015, advocate for firearm safety, safer methods for dispensing potentially lethal quantities of medications and methods for reducing carbon monoxide poisoning from automobile exhaust systems	Support and sponsor legislative efforts in the improvement of technologies to prevent elderly suicide by lethal means Remain knowledgeable of current topics and support national advocacy efforts in this area

Goal 10: Promote and Support Research on Suicide Behavior and Prevention

YOUTH (AGES 10–24)

Objectives:	*Strategies:*
By 2015, develop a statewide suicide research agenda with input from survivors, practitioners, researchers and advocates	Include research on aspects of prevention, intervention or postvention, including basic, applied, clinical, evaluation, community-based intervention and media-based research
By 2015, increase funding (public and private) for suicide prevention research including the translation of scientific knowledge into practice	Apply for public and private funding through collaboration with federal, state and local stakeholders Leverage existing resources to maximize funding for suicide prevention research
By 2015, establish and maintain a Delaware registry of prevention activities with demonstrated effectiveness for preventing suicide or suicidal behaviors	Review existing research to gather findings that have the most potential for application in community and clinical settings Make the registry available to individuals or communities so they can apply them or build upon them in developing local youth suicide prevention initiatives

MIDDLE-AGED MEN

Objectives:	*Strategies:*
By 2015, develop a statewide suicide research agenda with input from survivors, practitioners, researchers and advocates	Include research on aspects of prevention, intervention or postvention, including basic, applied, clinical, evaluation, community-based intervention and media-based research
By 2015, increase funding (public and private) for suicide prevention research including the translation of scientific knowledge into practice	Apply for public and private funding through collaboration with federal, state and local stakeholders Leverage existing resources to maximize funding for suicide prevention research
By 2015, establish and maintain a Delaware registry of prevention activities with demonstrated effectiveness for preventing suicide or suicidal behaviors	Review existing research to gather findings that have the most potential for application in community and clinical settings Make the registry available to individuals or communities so they can apply them or build upon them in developing local middle-aged suicide prevention initiatives

ELDERLY

Objectives:	*Strategies:*
By 2015, develop a statewide suicide research agenda with input from survivors, practitioners, researchers and advocates	Include research on aspects of prevention, intervention or postvention, including basic, applied, clinical, evaluation, community-based intervention and media-based research
By 2015, increase funding (public and private) for suicide prevention research including the translation of scientific knowledge into practice and the training of researchers in elder suicidology	Apply for public and private funding through collaboration with federal, state and local stakeholders Leverage existing resources to maximize funding for suicide prevention research
By 2015, establish and maintain a Delaware registry of prevention activities with demonstrated effectiveness for preventing suicide or suicidal behaviors	Review existing research to gather findings that have the most potential for application in community and clinical settings Make the registry available to individuals or communities so they can apply them or build upon them in developing local elderly suicide prevention initiatives

Goal 11: Improve and Expand Surveillance Systems

YOUTH (AGES 10–24)

Objectives:	*Strategies:*
By 2015, develop and implement standardized protocols for death scene investigations	Review emergency medical services protocols for suicide scene procedures and revise as needed Provide training to emergency medical technicians, medical examiners, fire fighters, police and coroners in gathering evidence from a suicide scene

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YOUTH (AGES 10–24) CONT.

Objectives: cont.	*Strategies: cont.*
By 2015, increase the number of jurisdictions that regularly collect and provide information for follow-back studies of suicides	Determine if a local jurisdiction regularly completes follow-back studies on completed suicides; if not, advocate for follow-back studies Support already-existing initiatives (e.g., Child Death, Near Death and Stillbirth Commission; Morbidity and Mortality Committees)
By 2015, increase the number of hospitals that collect uniform and reliable data on suicidal behavior by coding external causes of injuries	Advocate for mandated coding of external causes of injury by all hospitals
By 2015, increase the number of state survey instruments that include questions on suicidal behavior	Advocate for separate questions for suicidal behaviors in state surveys
By 2015, implement a statewide violent death reporting system that includes suicides and collects information not currently available from death certificates	Review current practices and ensure that nationally recognized reporting systems are in line with state practices
By 2015, increase the number of annual reports on suicide and suicide attempts	Review current practices and ensure that nationally recognized reporting systems are in line with state practices Encourage state health agencies to produce reports on suicide
By 2015, support pilot projects to link and analyze information on self-destructive behavior from various distinct data systems	Link data systems from law enforcement, emergency medical services, hospitals and other public health agencies Eliminate barriers with respect to data linkage including difficulties in obtaining access to various data sets, maintaining databases and issues of confidentiality Analyze linked data systems to provide more comprehensive information about youth suicide and suicide attempts

MIDDLE-AGED MEN

Objectives:	*Strategies:*
By 2015, develop and implement standardized protocols for death scene investigations	Review emergency medical services protocols for suicide scene procedures and revise as needed Provide training to emergency medical technicians, medical examiners, fire fighters, police and coroners in gathering evidence from a suicide scene
By 2015, increase the number of jurisdictions that regularly collect and provide information for follow-back studies of suicides	Determine if a local jurisdiction regularly completes follow-back studies on completed suicides; if not, advocate for follow-back studies Adopt the Child Death Review Board model to apply to middle-aged suicide deaths
By 2015, increase the number of hospitals that collect uniform and reliable data on suicidal behavior by coding external causes of injuries	Advocate for mandated coding of external causes of injury by all hospitals

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MIDDLE-AGED MEN CONT.

Objectives: *cont.*	*Strategies:* *cont.*
By 2015, increase the number of state survey instruments that include questions on suicidal behavior	Advocate for separate questions for suicidal behaviors in state surveys
By 2015, implement a statewide violent death reporting system that includes suicides and collects information not currently available from death certificates	Review current practices and ensure that nationally recognized reporting systems are in line with state practices
By 2015, increase the number of annual reports on suicide and suicide attempts	Review current practices and ensure that nationally recognized reporting systems are in line with state practices Encourage state health agencies to produce reports on suicide
By 2015, support pilot projects to link and analyze information on self-destructive behavior from various distinct data systems	Link data systems from law enforcement, emergency medical services, hospitals and other public health agencies Eliminate barriers with respect to data linkage including difficulties in obtaining access to various data sets, maintaining databases and issues of confidentiality Analyze linked data systems to provide more comprehensive information about middle-aged suicide and suicide attempts

ELDERLY

Objectives:	*Strategies:*
By 2015, develop and implement standardized protocols for death scene investigations	Review emergency medical services protocols for suicide scene procedures and revise as needed Provide training to emergency medical technicians, medical examiners, fire fighters, police and coroners in gathering evidence from a suicide scene
By 2015, increase the number of jurisdictions that regularly collect and provide information for follow-back studies of suicides	Determine if a local jurisdiction regularly completes follow-back studies on completed suicides; if not, advocate for follow-back studies Adopt the Child Death Review Board model to apply to elderly suicide deaths
By 2015, increase the number of hospitals that collect uniform and reliable data on suicidal behavior by coding external causes of injuries	Advocate for mandated coding of external causes of injury by all hospitals
By 2015, increase the number of state survey instruments that include questions on suicidal behavior	Advocate for separate questions for suicidal behaviors in state surveys
By 2015, implement a statewide violent death reporting system that includes suicides and collects information not currently available from death certificates	Review current practices and ensure that nationally recognized reporting systems are in line with state practices

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ELDERLY CONT.

Objectives: *cont.*	*Strategies:* *cont.*
By 2015, increase the number of annual reports on suicide and suicide attempts	Review emergency medical services protocols for suicide scene procedures and revise as needed Encourage state health agencies to produce reports on suicide
By 2015, support pilot projects to link and analyze information on self-destructive behavior from various distinct data systems	Link data systems from law enforcement, emergency medical services, hospitals and other public health agencies Eliminate barriers with respect to data linkage including difficulties in obtaining access to various data sets, maintaining databases and issues of confidentiality Analyze linked data systems to provide more comprehensive information about elderly suicide and suicide attempts

GLOSSARY

Appendix E

Activities the specific steps that will be undertaken in the implementation of a plan; activities specify the manner in which objectives and goals will be met.

Adolescence the period of physical and psychological development from the onset of puberty to maturity.

Advocacy groups organizations that work in a variety of ways to foster change with respect to a societal issue.

Affective disorders see Mood disorders.

Anxiety disorder an unpleasant feeling of fear or apprehension accompanied by increased physiological arousal, defined according to clinically derived standard psychiatric diagnostic criteria.

Best practices activities or programs that are in keeping with the best available evidence regarding what is effective.

Biopsychosocial approach an approach to suicide prevention that focuses on those biological, psychological and social factors that may be causes, correlates and/or consequences of mental health or mental illness and that may affect suicidal behavior.

Bipolar disorder a mood disorder characterized by the presence or history of manic episodes, usually, but not necessarily, alternating with depressive episodes.

Causal factor a condition that alone is sufficient to produce a disorder.

Cognitive/Cognition the general ability to organize, process and recall information.

Community a group of people residing in the same locality or sharing a common interest.

Comprehensive suicide prevention plans plans that use a multifaceted approach to addressing the problem; for example, including interventions targeting biopsychosocial, social and environmental factors.

Comorbidity the co-occurrence of two or more disorders, such as depressive disorder with substance abuse disorder.

Connectedness closeness to an individual, group or people within a specific organization; perceived caring by others; satisfaction with relationship to others, or feeling loved and wanted by others.

Consumer a person using or having used a health service.

Contagion a phenomenon whereby susceptible persons are influenced toward suicidal behavior through knowledge of another person's suicidal acts.

Culturally appropriate a set of values, behaviors, attitudes and practices reflected in the work of an organization or program that enables it to be effective across cultures; includes the ability of the program to honor and respect the beliefs, language, interpersonal styles and behaviors of individuals and families receiving services.

Culture the integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, faith or social group.

Depression a constellation of emotional, cognitive and somatic signs and symptoms, including sustained sad mood or lack of pleasure.

Effective prevention programs that have been scientifically evaluated and shown to decrease an adverse outcome or increase a beneficial one in the target group more than in a comparison group.

Elderly persons age 51 or older.

Environmental approach an approach that attempts to influence either the physical environment (such as reducing access to lethal means) or the social environment (such as providing work or academic opportunities).

Epidemiology the study of statistics and trends in health and disease across communities.

Evaluation the systematic investigation of the value and impact of an intervention or program.

Evidence-based programs that have undergone scientific evaluation and have proven to be effective.

Follow-back study the collection of detailed information about a deceased individual from a person familiar with the decedent's life history or from other resources. The information collected supplements that individual's death certificate and details his or her circumstances, the immediate antecedents of the suicide, and other important but less immediate antecedents.

Frequency the number of occurrences of a disease or injury in a given unit of time; with respect to suicide, frequency applies only to suicidal behaviors that can repeat over time.

Gatekeepers those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate.

Goal a broad and high-level statement of general purpose to guide planning around an issue; it is focused on the end result of the work.

Health the complete state of physical, mental and social well-being, not merely the absence of disease or infirmity.

Health and safety officials law enforcement officers, fire fighters, emergency medical technicians (EMTs) and outreach workers in community health programs.

Healthy People 2010 the national prevention initiative that identifies opportunities to improve the health of all Americans, with specific and measurable objectives to be met by 2010.

Indicated prevention intervention intervention designed for individuals at high risk for a condition or disorder or for those who have already exhibited the condition or disorder.

Intentional injuries injuries resulting from purposeful human action whether directed at oneself (self-directed) or others (assaultive), sometimes referred to as violent injuries.

Intervention a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (such as providing lithium for bipolar disorder or strengthening social support in a community).

Means the instrument or object whereby a self-destructive act is carried out (e.g., firearm, poison, medication).

Means restriction techniques, policies and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

Methods actions or techniques that result in an individual inflicting self-harm (e.g., asphyxiation, overdose, jumping).

Mental disorder a diagnosable illness characterized by alterations in thinking, mood or behavior (or some combination thereof) associated with distress that significantly interferes with an individual's cognitive, emotional or social abilities; often used interchangeably with mental illness.

Mental health the capacity of individuals to interact with one another and the environment in ways that promote subjective well-being, optimal development and use of mental abilities (cognitive, affective and relational).

Mental health problem used when cognitive, social or emotional abilities are diminished but not to the extent that the criteria for a mental disorder are met.

Mental health services health services that are specially designed for the care and treatment of people with mental health problems, including mental illness; includes hospital and other 24-hour services, intensive community services, ambulatory or outpatient services, medical management, case management, intensive psychosocial rehabilitation services, and other intensive outreach approaches to the care of individuals with severe disorders.

Mental illness see Mental disorder.

Mood disorders a term used to describe all mental disorders that are characterized by a prominent or persistent mood disturbance; disturbances can be in the direction of elevated expansive emotional states or, if in the opposite direction, depressed emotional states; included are depressive disorders, bipolar disorders, mood disorders due to a medical condition and substance-induced mood disorders.

Morbidity the relative frequency of illness or injury, or the illness or injury rate, in a community or population.

Mortality the relative frequency of death, or the death rate, in a community or population.

Objective a specific and measurable statement that clearly identifies what is to be achieved in a plan; it narrows a goal by specifying who, what, when and where, or clarifies by how much, how many or how often.

Outcome a measurable change in the health of an individual or group of people that is attributable to an intervention.

Outreach programs programs that send staff into communities to deliver services or recruit participants.

Personality disorders a class of mental disorders characterized by deeply ingrained, often inflexible, maladaptive patterns of relating, perceiving and thinking of sufficient severity to cause either impairment in functioning or distress.

Postvention a strategy or approach that is implemented after a crisis or traumatic event has occurred.

Prevention a strategy or approach that reduces the likelihood or risk of onset, delays the onset of adverse health problems, or reduces the harm resulting from conditions or behaviors.

Protective factors factors that make it less likely that individuals will develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment.

Psychiatric disorder see Mental disorder.

Psychiatry the medical science that deals with the origin, diagnosis, prevention and treatment of mental disorders.

Psychology the science concerned with the individual behavior of humans, including mental and physiological processes related to behavior.

Public information campaigns large-scale efforts designed to provide facts to the general public through various media such as radio, television, advertisements, newspapers, magazines and billboards.

Rate the number per unit of the population with a particular characteristic for a given unit of time.

Residency programs postgraduate clinical training programs in special subject areas such as medicine.

Resilience capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

Risk factors those factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment.

Screening administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment.

Screening tools those instruments and techniques (questionnaires, checklists, self-assessments forms) used to evaluate individuals for increased risk of certain health problems.

Selective prevention intervention intervention targeted to subgroups of the population whose risk of developing a health problem is significantly higher than average.

Self-harm the various methods by which individuals injure themselves, such as self-laceration, self-battering, taking overdoses or exhibiting deliberate recklessness.

Self-injury see Self-harm.

Sociocultural approach an approach to suicide prevention that attempts to affect the society at large, or particular subcultures within it, to reduce the likelihood of suicide (such as adult-youth mentoring programs designed to improve the well-being of youth).

Social services organized efforts to advance human welfare, such as home-delivered meal programs, support groups and community recreation projects.

Social support assistance that may include companionship, emotional backing, cognitive guidance, material aid and special services.

Specialty treatment centers (e.g., mental health/substance abuse centers) health facilities where the personnel and resources focus on specific aspects of psychological or behavioral well-being.

Stakeholders entities, including organizations, groups and individuals, that are affected by and contribute to decisions, consultations and policies.

Stigma an object, idea or label associated with disgrace or reproach.

Substance abuse a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use; includes maladaptive use of legal substances such as alcohol; prescription drugs such as analgesics, sedatives, tranquilizers and stimulants; and illicit drugs such as marijuana, cocaine, inhalants, hallucinogens and heroin.

Suicidal act (also referred to as suicide attempt) a potentially self-injurious behavior for which there is evidence that the person probably intended to kill himself or herself; a suicidal act may result in death, injury or no injury.

Suicidal behavior a spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts and completed suicide.

Suicidal ideation self-reported thoughts of engaging in suicide-related behavior.

Suicidality a term that encompasses suicidal thoughts, ideation, plans, suicide attempts and completed suicide.

Suicide death from injury, poisoning or suffocation for which there is evidence that a self-inflicted act led to the person's death.

Suicide attempt a potentially self-injurious behavior with a nonfatal outcome for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injury.

Suicide attempt survivors individuals who have survived a suicide attempt.

Suicide survivors family members, significant others or acquaintances who have experienced the loss of a loved one due to suicide; sometimes this term is also used to mean suicide attempt survivors.

Surveillance the ongoing, systematic collection, analysis and interpretation of health data with timely dissemination of findings.

Unintentional term used for an injury that is unplanned; in many settings these are termed accidental injuries.

Universal preventive intervention intervention targeted to a defined population, regardless of risk; this could be an entire school, for example, and not the general population.

Utilization management guidelines policies and procedures that are designed to ensure efficient and effective delivery (utilization) of services in an organization.

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Child Death, Near Death and Stillbirth Commission

Contact Lifeline

Delaware Attorney General's Office, Department of Justice

Delaware National Guard

Delaware River and Bay Authority

Department of Corrections
- Correctional Medical Services

Department of Education

Department of Public Safety and Homeland Security
- Delaware State Police

Department of Services for Children, Youth and Their Families
- Division of Child Mental Health Services
- Office of Prevention and Early Intervention

Delaware Health and Social Services
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